

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way

Name: _____ Other Name(s): _____

Address: _____ Phone: _____

Social Security #: _____ Date of Birth: _____

I authorize the Department of Mental Health (DMH) to receive and release information from or to the person, agency or facility named below, either verbally or in writing, as indicated in this authorization.

Name: _____ Attention: _____ Phone: _____

Street: _____ City/Town: _____ State: _____ Zip: _____

DMH Contact Information:

Name: _____ Phone: _____

Address: _____

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request. Specify information to be released e.g., Entire Record, Admission(s) Documentation, Discharge Summary(ies), Transfer Summary(ies), Evaluations, Assessments and Tests, Consultation(s) including names of consultant(s), Treatment Plan(s), ISP(s) & PSTP(s), Physical Exam & Lab Reports, Progress Note(s):

Purpose for the authorization:

☐ The subject of the information or Personal Representative initiated the authorization (specific purpose not required)

or

☐ Coordinate care

☐ Facilitate billing

☐ Referral

☐ Obtain insurance, financial or other benefits

☐ Other purpose (please specify)

A copy of this authorization shall be considered as valid as the original.

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Authorization for Release of Information
Two-Way (continued)

Name of person/facility/agency other than DMH to receive or release information: _____

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to DMH at DMH address identified on page one. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire (specify a date, time period or an event) _____ or, if nothing is specified, it will expire when I am no longer receiving services from DMH. I understand that once the above information is disclosed to a person, facility or agency outside DMH, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to receive treatment or services from DMH and/or the other named person, facility or agency. However, lack of ability to share or obtain information may prevent DMH, and/or the other named person, facility or agency, from providing appropriate and necessary care.

Your signature or Personal Representative's signature

Date

Print name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent) _____

Specially Authorized Releases of Information (please initial all that apply)

_____ To the extent that my medical record contains information concerning alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I specifically authorize release of such information.

_____ To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by MGL c.111 §70F, an HIV/AIDS diagnosis or treatment, I specifically authorize disclosure of such information.

Your signature or Personal Representative's signature

Date

INSTRUCTIONS:

1. This form must be completed in full to be considered valid.
 2. Distribution of copies: original to appropriate DMH record; copy to Individual or Personal Representative; copy to person/facility/agency making request.
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